Missouri First steps EARLY INTERVENTION

CFO PROVIDER ENROLLMENT

Attn: Provider Enrollment
Covansys
P. O. Box 29134
Shawnee Mission KS 66201- 9134

Provider Enrollment 866-711-2573 Option 2 Fax: 913.888.6683 http://missouri.eikids.com Email: mofsenroll@pdainc.com

Provider Information

Please complete this form using the organization information or your information if you are an Independent provider.
If you are currently enrolled, please provide the information currently in the CFO system. Send completed form to the address at the top.

Payee Federal Tax Id Number: _____ Payee/Facility Name: _____

First Name: _____ M: _____ Last Name: _____ Email: _____

Site Address(services are performed here) _____

City: _____ State _____ Zip: _____

Phone: ( ) - EXT: Fax: ( ) -

Name Of Primary Contact for Enrollment Questions:

Billing Information

- ❑ **New Information**
- ❑ **Change of Information**

Please indicate the type of change: ___Specialty ___Name ___Phone ___Fax ____Address ____Site ___Billing

___ Dis-Enrolling: Last Date Of Work____/____/____ ___Re-Enrollment Facility ___Re-Enrollment Independent

Payee/Facility Name: _____

ProviderName: _____ Specialty Level (Circle One): Associate or Specialist

Billing Address: _____

City: _____ State: _____ ZIP: _____

Phone: ( ) - EXT: Fax: ( ) -

Are You Currently Enrolled by the first steps System as an Early Intervention Practitioner? ___No ____Yes
If yes, how are you currently enrolled? ___Independently ___With a Facility ____Both

Early Intervention Discipline

Please select one of the following service types indicating the designation for your enrollment.___

____ ABA Consultant
____ ABA Implementer
____ Assistive Technology Provider
____ Audiologist
____ Counselor
____ Dietitian
____ Foreign Language Translator
____ Interpreters for the Deaf
____ Nurse (Licensed Practical Nurse)
____ Nurse (Registered)
____ Occupational Therapy Assistant (COTA) Certified
____ Occupational Therapist
____ Optometrist
____ Orientation/Mobility Specialist
____ Paraprofessional In Early Intervention
____ Parent Advisor for Hearing Impairments
____ Parent Advisor for Visual Impairments
____ Physical Therapist
____ Physical Therapy Assistant (PTA)
____
____ Physician
____ Psychologist
____ Service/Intake Coordinator
____ Service/Intake Coordinator (Assoc Level)
____ Social Worker
____ Special Instructor/Developmental Therapist
____ Speech Pathologist
____ Speech Pathologist Associate
____ Transportation Provider
____
____ Other (Please Specify) _____

Please be aware that you may not provide services until you are listed as a provider at your local System Point Of Entry (SPOE).
If you are requesting a change in status (i.e. from associate to specialist level) that requires supporting documentation (Degree, License, etc), please attach the documentation to this form. If you are requesting a change in payee name or individual name please complete a W-9 form available on the website and submit it to our office with this form. Provider status will be updated upon the receipt of completed agreements. The date the information is received at the CFO office will determine the effective date of your provider status.

Signature: _____ Date _____

The Missouri Personnel Standards for Early Intervention Providers can be downloaded from the Internet at
http://www.dese.state.mo.us/divspeced/PDF/Credential%20Packet2.pdf